PRELIMINARY REPORT OF REVIEW OF PREPAID HEALTH PLANS FOR MEDI-CAL RECIPIENTS

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VINCENT THOMAS
CHAIRMAN

ROOM 4126, STATE CAPITOL
SACRAMENTO, CALIFORNIA 95814
(916) 445-7906

MERRILL E. TOMPKINS, C.P.A., COORDINATOR
(916) 445-1630

EVE OSTOJA, OFFICE MANAGER
(916) 445-7908

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The Honorable President of the Senate
The Honorable Speaker of the House
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members:

Transmitted herewith is a preliminary report in conformance with your request for a performance audit of prepaid health plans for Medi-Cal recipients. Prepaid health plans were devised to provide Medi-Cal recipients an alternative to the fee-for-service method of health care delivery. The objectives of prepaid health plans are to improve medical care received by beneficiaries while reducing the costs of these services.

The state is paying, on a fee-for-service basis, for care provided to some Medi-Cal recipients who are enrolled in prepaid health plans. The prepaid health plans are paid on a monthly basis to provide all needed health services to these same enrollees. The full extent of such duplicate payments has not been established.

Both criminal and civil actions have been instituted by District Attorneys charging that certain representatives of prepaid health plans are using fraudulent practices to enroll Medi-Cal recipients.

The Department of Health Care Services has not coordinated with local agencies and consumer groups in the development and marketing of prepaid health plans. In one example reviewed, county personnel were not even aware of the existence of a particular plan in their county until complaints were received from recipients about the plan. It has, therefore, been impossible for social workers to provide health plan guidance and counsel to their caseload.

Although the department has had the authority and responsibility to institute procedures to adequately control and manage prepaid health plans, the department has failed to do so. Uniform accounting and reporting procedures have not been developed or required and data necessary to evaluate the overall effect of the plans is not available.

The department is not taking necessary precautions to assure that all prepaid health plan providers have the capability to deliver contracted services. A review of the providers used by five of the prepaid health plans disclosed that some of the providers have not been reported to the department. Also, one hospital listed as a provider has filed a complaint stating that it is in no way associated with the plan.

Rivalry between the plans for enrollments is keen and enrollers are generally paid on a commission basis. The department has approved plans with a great deal of geographic overlapping; and in San Diego County, the department has contracted with prepaid health plans to enroll more Medi-Cal recipients than exist in the county. These actions, approved and contracted by the department encourage fraudulent enrollment procedures and serve to confuse the Medi-Cal recipient.

The presentation of prepaid health plans as nonprofit is misleading. Although the primary contracts for the plans are generally between the state and nonprofit corporations, most of the contracted services are provided through profit-oriented organizations. Some of the profit and nonprofit organizations are financially interrelated and some have the same stockholders and officers.

On the instruction of the director, Department of Health personnel have delayed and refused access to documentation and personnel essential to the completion of an independent review and analysis of prepaid health plans.

Respectfully submitted,

Vincent Thomas

VINCENT THOMAS, Chairman
Joint Legislative Audit Committee

SUMMARY

We are in the process of a program evaluation of prepaid health plans for Medi-Cal recipients. This program is administered by the new Department of Health and prior to July 1, 1973 was the responsibility of the Department of Health Care Services.

The completion of this evaluation has been delayed by restrictions placed on access to personnel and documents essential to an independent analysis of prepaid health plans. This preliminary report is being issued in response to a legislative request specifically requesting a report at this time.

The following findings and conclusions have been developed at this point in our review.

Findings — Page

1. The State is Paying More than once for Medical Services Provided to some Medi-Cal Recipients Enrolled in Prepaid Health Plans. 5

2. The Delivery of Health Services Under Prepaid Health Plans Is Profit Motivated and the Presentation of these Plans As "Nonprofit" Is Misleading. 6

3. Certain Prepaid Health Plan Representatives Have Been Charged With Using Fraudulent Practices to Enroll Medi-Cal Recipients. 7

INTRODUCTION

In response to a legislative request, we are conducting a performance audit of prepaid health plans. In conducting this evaluation we are reviewing documentation at the Department of Health, the local governmental units involved, the fiscal intermediaries processing fee-for-service Medi-Cal claims, and at the prepaid health plans. We are also in the process of contacting various providers and enrollees under the plans. To date, our contacts with personnel outside the Department of Health have been primarily in Los Angeles and San Diego Counties. These contacts will be expanded to other counties prior to the completion of the study.

Prepaid health plans (PHPs) for Medi-Cal beneficiaries were first authorized by the Legislature in 1966 (Chapter 4, Statutes of 1965, 2nd Ex. Sess.) and are now provided for in the Waxman-Duffy Prepaid Health Plan Act (Chapter 8, commencing with Section 14200, Pt. 3, Div. 9, W.& I. Code). A prepaid health plan is now defined in Section 14251 as:

> "...any carrier or association of providers of medical and health services who agree with the Department ... to furnish directly or indirectly health services to Medi-cal beneficiaries on a pre-determined periodic rate basis ..."

Prepaid health plans provide an alternative to the fee-for-service method of health care delivery for Medi-Cal beneficiaries and were devised to improve the medical care received by these recipients while reducing the costs of the services to the state.

The first contract for a prepaid health plan which was not a pilot project was effective May 1, 1972. At July 1, 1973 there were 47 contracts for prepaid health plans in force. The maximum number of enrollees authorized under these plans exceeds 855,000 Medi-Cal beneficiaries at a maximum annual cost in excess of $230 million. The actual number of beneficiaries enrolled in prepaid health plans at July 1, 1973 was 178,372 and the actual cost for 1972-73 fiscal year, on a cash basis was approximately $37 million.

1. THE STATE IS PAYING MORE THAN ONCE FOR MEDICAL SERVICES PROVIDED TO SOME MEDI-CAL RECIPIENTS ENROLLED IN PREPAID HEALTH PLANS.

Records of a randomly selected sample of 1,213 Medi-Cal recipients enrolled in prepaid health plans were reviewed. Approximately ten percent of the enrollees reviewed received medical services which the state paid for on a fee-for-service basis while the state was also paying prepaid health plans contractually agreed monthly amounts to provide these enrollees with all needed medical services.

The records of enrollees under five prepaid health plan contracts were reviewed. The percentage of enrollees in the sample for whom such duplicate payments were made varied from a low of four percent in one plan to a high of 18 percent in another.

These duplicate payments are a direct reflection of inadequate management and accounting controls exercised by the Department of Health Care Services.

2. THE DELIVERY OF HEALTH SERVICES UNDER PREPAID HEALTH PLANS IS PROFIT MOTIVATED AND THE PRESENTATION OF THESE PLANS AS "NONPROFIT" IS MISLEADING.

The Department of Health Care Services and the current Department of Health has administratively determined to contract primarily with nonprofit organizations for the development and operation of prepaid health plans (PHPs).

Although the PHP contracts of those plans which we have reviewed are between the state and nonprofit corporations, the delivery of the contracted services is provided primarily through profit oriented organizations. These organizations are financially interrelated to the nonprofit corporations. The profit oriented organizations have the same stockholders and officers as the related nonprofit oriented organizations. In some instances, the nonprofit corporation is a wholly-owned subsidiary of a profit oriented holding company.

Most of the hospitals, clinics, pharmaceutical suppliers, x-ray and laboratory facilities and patient transportation facilities which provide services to the Medi-Cal beneficiaries under these PHPs are owned by, or contracted through, principals in the nonprofit corporations or by corporations which are subsidiary to a holding company in common with the nonprofit corporation. In addition, management, consultants, and data processing services are provided to the nonprofit corporations either by firms that are controlled by principals in the nonprofit organizations or that are subsidiaries of the same holding companies controlling the nonprofit corporations.

3. CERTAIN PREPAID HEALTH PLAN REPRESENTATIVES HAVE BEEN CHARGED WITH USING FRAUDULENT PRACTICES TO ENROLL MEDI-CAL RECIPIENTS.

Fraud investigation units in the Los Angeles County and San Diego County District Attorney's offices have been receiving complaints alleging forgery and false and misleading representation in enrolling Medi-Cal recipients in certain prepaid health plans.

Grand Jury indictments on 14 counts of forgery involving prepaid health plan enrollment contracts have been obtained by the Los Angeles County District Attorney. A civil suit alleging ten counts of false and misleading representation of a prepaid health plan has been filed by the San Diego County District Attorney. The San Diego suit involves a Los Angeles based prepaid health plan that was recently franchised by the state to operate in the San Diego area.

Certain enrollers employed by the prepaid health plans are customarily paid a commission for each enrollee they succeed in signing up and this arrangement results in the use of high pressure sales techniques with their resultant abuses. Many Medi-Cal beneficiaries have charged that enrollers misrepresent themselves as county or state employees or as paramedical practitioners. The Medi-Cal recipient who is usually solicited through door-to-door canvassing in low rent neighborhoods is led to believe that Medi-Cal is being terminated and there is no alternative except to enroll in the prepaid health plan. These enrollers additionally misrepresent the plan by telling recipients that they can continue to see their own regular physician after enrollment and that free transportation to and from the health care clinics will be provided.

4. THE DEPARTMENT OF HEALTH CARE SERVICES HAS FAILED TO COORDINATE WITH LOCAL AGENCIES AND CONSUMER GROUPS IN MARKETING PREPAID HEALTH PLANS.

County welfare departments, welfare rights organizations and community groups have not been included in prepaid health plan planning activities nor has their counsel or support been solicited by the Department of Health Care Services in furthering the acceptance of prepaid health plans.

Welfare recipients traditionally rely on their welfare caseworker for guidance and counsel in matters relating to eligibility and benefits. DHCS has consistently failed to advise county welfare departments as to plans and new developments concerning prepaid health plans. In San Diego, social workers were not aware of a prepaid health plan's existence until complaints from recipients started to come in. Social workers were not able to advise their clients as to the proper course of action because they themselves had no knowledge of the plan and its features and limitations. A civil suit has now been instituted in San Diego against this plan alleging ten counts of false and misleading representation.

5. THE DEPARTMENT OF HEALTH CARE SERVICES HAS FAILED TO INSTITUTE PROCEDURES TO PROVIDE PROPER CONTROL AND MANAGEMENT OF PREPAID HEALTH PLANS.

In addition to the problem areas which have already been discussed, the following discrepancies are directly attributable to poor management by the Department of Health Care Services.

Uniform Accounting and Reporting Procedures For Prepaid Health Plans Have Not Been Developed and Required by the Department

Section 14161 of the Welfare and Institutions Code enacted in 1971, established the requirement that carriers and providers of Medi-Cal benefits utilize uniform accounting and cost reporting systems as shall be developed and adopted by the department.

Because the department has not exercised this authority, the data necessary to evaluate the overall effect of the prepaid health plans or individual plans within the program is not available. In addition, such data as is submitted is not prepared on the same basis and is, therefore, not comparable.

This requirement was restated and expanded in the Waxman-Duffy Prepaid Health Plan Act which became operative on July 1, 1973 and provides (in Section 14310 of the Welfare and Institutions Code) that prepaid health plans shall furnish the director such timely information and reports as he may find necessary.

The Department Has Not Taken Steps to Assure That Lists of Providers Submitted by Prepaid Health Plans Are Accurate and Complete.

The information package prepared by the Department of Health Care Services for parties desiring to secure prepaid health plan contracts contains explicit instructions to applicants to list all providers under the proposed plan. This enables the department to insure that these providers have the capability to deliver the contracted services.

A review of the providers used by five of the prepaid health plans disclosed that some of these providers have not been reported to the department. Also, in one instance, a hospital listed as a provider in both the proposal submitted to the department and in departmental approved advertisements has filed a complaint stating that the hospital is in no way associated with the plan.

The Department Has Approved Prepaid Health Plans With a Great Deal of Overlapping Of Geographic Areas by Different Plans.

We have reviewed hundreds of complaints from Medi-Cal recipients and providers regarding fraudulent and unethical enrollment techniques employed by different plans. As mentioned earlier in this report, both civil and criminal actions have been instigated as a result of some of these complaints. The concentration of many plans in restricted geographic areas serves to further bewilder and confuse the Medi-Cal recipients and encourage fraudulent enrollment practices by enrollees.

There is one area west of Compton in Los Angeles County where at least 13 organizations are competing for prepaid health plan enrollments. In San Diego the department has entered into contracts to provide services to a maximum number of prepaid health plan enrollees which is greater than the total number of Medi-Cal beneficiaries in the county in May 1973.

Aid Programs	Contracted Maximum Enrollees	County Eligible Recipients
AFDC	65,490	65,458
AB	3,620	821
OAS	15,986	15,026
ATD	11,504	10,070
TOTAL	96,600	91,375

6. THE DEPARTMENT OF HEALTH AND PRIOR TO JULY 1, 1973, THE DEPARTMENT OF HEALTH CARE SERVICES, HAS RESTRICTED AUDITORS' ACCESS TO DOCUMENTATION OF PREPAID HEALTH PLANS.

At the direction of the director, personnel at the Department of Health, and the Department of Health Care Services prior to July 1, 1973, have restricted access to records and personnel considered essential for the completion of an independent review and analysis of prepaid health plans.

Personnel either have refused to provide or have delayed in providing documentation regarding contract negotiation, development of rate structures, billing information, correspondence between the department and prepaid health plans and fiscal intermediaries and individual Medi-Cal enrollee information.

A variety of reasons have been presented for refusing this access. The most recent reason presented is the confidentiality of records imposed by the federal government. However, when it was explained that beneficiaries names could be removed from certain requested documents, therefore eliminating the question of confidentiality, the Director of the Department of Health has still refused access to the needed documentation.

Due to the delays resulting from the departments' actions in restricting access to information, a final report on the review of prepaid health plans cannot be issued at this time. This preliminary report is being issued to disclose to the extent possible, apparent problem areas in the administration of the prepaid health plans.

Walter J. Quinn
Acting Deputy Auditor General

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Staff: John H. McConnell
Phillips Baker
Rosauro A. Luna
Nancy L. Szczepanik